Understanding the lived experiences of transitioning adults with gender dysphoria in the United Kingdom

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Understanding the Lived Experience of Transitioning Adults with Gender Dysphoria in the United Kingdom: An Interpretative Phenomenological Analysis

Abstract

Adults with Gender Dysphoria have shown to be at an increased risk of mental health issues, often as a result of barriers to accessing treatment and experiencing discrimination. This study aimed to gain an in-depth understanding of the lived experiences of adults with gender dysphoria seeking treatment in the United Kingdom (UK). Two transgender males and six transgender females participated. Data were collected via semi-structured interviews and analyzed using Interpretative Phenomenological Analysis. Analysis of the transcripts revealed three superordinate themes: "Accessing Healthcare Services," "Searching for Acceptance," and "Impact of Gender Dysphoria on Psychological Wellbeing," that represented the experience for this population. It is concluded that there is a substantial need for counseling support during and after the treatment seeking process within the UK.

Keywords: Gender, Transgender, Interpretative Phenomenological Analysis, LGBT+

Introduction

Formally known as Gender Identity Disorder, Gender Dysphoria (GD) is defined as an incongruence, for a duration of at least six months, between an individual's assigned gender and their experienced or expressed gender (American Psychiatric Association [APA], 2013). The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) criteria for GD adopts a polythetic conceptualization rather than a unitary set of diagnostic criteria. Symptoms range from impaired functioning in daily routine due to discomfort of assigned gender identity, and discomfort with current or anticipated gender development, and a desire to be treated as different to one's assigned gender (APA, 2013).

Seeking Treatment for GD in the United Kingdom

In the United Kingdom (UK) individuals seeking treatment for GD must be referred by a medical professional to a Gender Identity Clinic (GIC; National Health Service [NHS], 2019). Once a diagnosis of gender dysphoria is made, the medical professional and client will agree treatment goals. When considering treatment options for GD, some clients seek partial treatment, (e.g. hormone therapy), whereas others will seek triadic therapy (Wylie, Eden, & Watson, 2012). Triadic therapy consists of real-life experiences, hormone therapy and sex reassignment surgery (Wylie et al., 2012). However, accessing treatment for GD within England can be difficult. The NHS, a publicly funded national health care system, currently has only seven GICs in England for adults, and one clinic for adolescents (GIRES, 2015). As a result, those with GD are often experiencing lengthy wait times for consultation. As of October 31, 2017, individuals in the UK with GD are waiting on average 136 weeks for their first appointment at a GIC (NHS England, personal communication, December 21, 2017). These waiting times are in breach of clients' legal entitlement to have an appointment in a specialist care service within 18 weeks of referral

(Women and Equalities Committee, 2016). In addition, the unequal geographical distribution of clinics in the UK mean that clients may often have to travel long distances to access treatment (Women and Equalities Committee, 2016). Although not all individuals with GD access medical interventions, those that do wish to seek this form of support have identified that the long waiting time is a substantial barrier to accessing medical treatment (Bachmann & Gooch, 2018). Furthermore, research has demonstrated that one in four transgender individuals are not satisfied with the support received by their physician and GIC (Bachmann & Gooch, 2018).

The care of individuals with GD in the UK is managed via the National Health Service, who are, in turn, expected to follow the protocols outlined by the Royal College of Psychiatrists (RCP) with respect to the '*Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria*'[1] (RCP, 2013). Within these guidelines, the importance of the health service supporting clients in being actively involved in decision-making is emphasized. Active involvement is achieved by informing clients in detail about their treatment options, and the expected advantages and disadvantages of each treatment approach, as well as the probable outcomes of not pursuing treatment. Given the previously identified constraints in GIC treatment resources, it is evident that the RCP's guidelines (2013), stating that GD clients should be in contact with an endocrinologist who can support hormone therapy as an interim measure, is particularly pertinent within the UK context. The provision of hormone therapy during waiting periods for GD treatment is also supported by current WPATH guidelines (WPATH, 2012). In

[1] The '*Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria*' is a guidance document, reflecting the consensus of all relevant stakeholders, of expected standards of the healthcare of clients with Gender Dysphoria. The document is largely reflective of the international guidelines outlined within WPATH, however the Good Practice Guidelines are discussed within the specific context of the healthcare structure within the UK i.e. the *National Health Service* structure.

addition, the RCP guidelines (2013) emphasize that clear and swift communication regarding the expected treatment timelines, and promptly informing clients when delays occur, in order to minimize potential distress.

Within the Good Practice Guidelines proposed by the RCP, the multiple roles that the psychology counselor can play is emphasized throughout. The RCP proposed that the counselor has a valuable contribution to make in supporting the client to explore their experiences and treatment preferences if they are experiencing difficulty making decisions about potential treatment options (RCP, 2013). Furthermore, the counselor can assist clients with other psychological issues or disorders that can often co-occur with GD, such as depression. The guidelines further acknowledge that counselors are not only likely to be required to support the well-being of clients with GD before and during treatment, but also counseling in a post-operative context facilitates a positive prognosis (RCP, 2013).

Gender Transitioning in the UK Context

The transgender community often experience stigmatization, prejudice and discrimination in both social and medical environments, such as in school and the workplace as a result of their gender non-conformity (Byne et al., 2018). For example, Jaffee, Shires and Stroumsa (2016) found that 30.8% of transgender clients had faced discrimination in healthcare services, which resulted in delaying or refusing to seek needed medical care. In social settings, the transgender population also frequently experience verbal harassment and physical violence, particularly during the transition process (Lombardi, Wilchins, Priesing, & Malouf, 2001).

Previous research has indicated that experiencing social stigma is positively associated with psychological distress (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Nuttbrock et al., 2010). Transgender individuals often report higher levels of anxiety and

depression in comparison to the general population (Budge, Adelson, & Howard, 2013). Moreover, the rates of suicide attempts are high amongst the transgender community, particularly amongst transgender youth (Clements-Nolle, Marx, & Katz, 2006; Maguen & Shipherd, 2010). Maguen and Shipherd (2010) explain that experiencing transgender-related physical violence may be a precursor to suicide attempts. Despite the high prevalence of psychological distress repeatedly observed amongst those transitioning, there remains a scarcity of research that provides understanding of the emotional experiences of individuals with GD, with respect to their interaction with healthcare and treatment organizations. Evidently, it is important that transgender individuals have support in developing coping mechanisms that enable navigation in a society in which they anticipate negative reactions from others should they openly express their gender identity (Government Equalities Office, 2018).

Social support plays a central role as a protective factor for transgender individuals' mental health and can influence ease of transition (Bockting et al., 2013; Budge et al., 2013). Furthermore, familial support can be a protective factor against psychological distress amongst transgender persons (Bariola et al., 2015). However, parental reactions to gender non-conformity can range from accepting to rejecting (Katz-Wise, Rosario, & Tsappis, 2016), and familial rejection can substantially negatively impact the mental health of transgender adolescents. For example, Yadegarfard, Meinhold-Bergmann and Ho (2014) reported that familial rejection was a significant predictor of suicidal thoughts and depression amongst transgender adolescents. With respect to the UK, the RCP (2013), in their guidelines for good practice, emphasized the centrality of peer and familial support and acceptance to a positive prognosis for GD treatment outcomes as family disharmony was often identified as a source of post-operative regret in transgender clients. Moreover, it is argued that because of the initial reluctance of the client with

GD to seek treatment, because of apprehension of social conflict and discrimination, once in treatment, clients are eager to progress rapidly. The RCP (2013) proposed that this perceived *rapidity* of progression towards gender confirmation surgery is particularly difficult for clients' spouses and relatives to adapt to and accept, which often leads to further interpersonal conflict which clients can find distressing. As a result, the UK guidelines propose that psychological counseling to support the client in ameliorating interpersonal conflict, through measures such as family therapy, should be offered as standard within every package of care (RCP, 2013).

Rationale for Study

Given the daily challenges faced by individuals during gender transition, including accessing health care, societal prejudices, and the impact of transitioning on mental wellbeing, it is important to understand individual experiences in depth from the perspective of those who have experienced living with GD. To date, there is very little existing research that focuses on the understanding of living with GD in the UK using the narrative of transgender individuals. Although the provision of a National Health Service that is available to all individuals regardless of status is highly commendable and desirable, perennial budgetary limitations often can restrict the promptness of care within NHS (Mind, 2017). This is especially applicable with regards care for mental health issues in general, and also within domains where there are insufficient specialist resources (GIRES, 2015). Essentially, this translates to vast waiting times for initial appointments to NHS gender identity clinics for individuals with GD in the UK (NHS England, personal communication, December 21, 2017). Statistics indicate that only 60% of transgender people had been seen at a GIC within one year of initial referral. Approximately two thirds of transgender individuals felt that lengthy wait times had negatively impacted their mental health or emotional wellbeing (McNeil, Bailey, Ellis, & Morton, 2012).

This study contributes to literature by to revealing the psychological experience of clients with GD in the UK as they seek healthcare within the NHS. In doing so it also highlights opportunities to improve the care of GD clients within this context. This research proposes opportunities for psychological support via counseling roles, to address issues specific to experiencing GD, as well as issues emerging from the process of seeking treatment for GD within the NHS.

Method

Participants and Design

Two transgender males and six transgender females took part in this study (See Table 1). The mean age of participants was 33 years (SD = 12.69, range = 22 - 60). This sample size does carry with it some limitations. For example, one has to be circumspect when considering if these findings apply to the wider population. However, a small sample size is consistent with the aims of interpretative phenomenological analysis (IPA), which intends to reveal idiographic experiences in depth, rather than making generalizations across a wider sample size (Smith & Osborn, 2008).

Participants were recruited through purposive sampling (Palys, 2008), via advertising in transgender community groups on social media within the East Midlands region of the UK. Inclusion criteria specified that the participant identified as transgender and had been living for at least 12 months in their new gender role that is incongruent to their sex assigned at birth. All participants have either completed gender confirmation surgery, or were actively undergoing or seeking gender confirmation surgery. The majority of participants at the time of data collection were participating in hormone therapy, with one participant actively seeking hormone therapy. Therefore, the participant who was actively seeking treatment was only able to comment on their

experience of being in the referral process. However, the remaining participants were able to retrospectively reflect on their experience of the referral process in addition to their experiences of treatment. All names have been replaced with pseudonyms to protect anonymity, and all identifiable details of the participants that were not essential to the study were removed from the data. Data were collected through semi-structured interviews and analyzed using Interpretative Phenomenological Analysis (Smith & Osborn, 2003).

[INSERT TABLE 1 ABOUT HERE]

Data Collection

Ethical approval was obtained from the School of Psychology Research Ethics Committee (SOPREC) at the University of "MASKED FOR REVIEW" (Ethical clearance number: 12102017). Before data collection began, informed consent was obtained from all participants included in the study. Data were collected through semi-structured interviews, which lasted approximately 60 minutes each. Interviews were audio recorded and conducted in a private space, then transcribed verbatim. Interview questions were designed to be open, yet specific to participants' experiences of transitioning and living with GD; for example, "*Tell me about your experience of transitioning and what it entailed*?" During the interview, the researchers' line of questioning was guided by participant responses to previous questions. Researchers' aimed to allow participants to inform the direction of the interview where possible, to facilitate the emergence of unanticipated topics, and for participants to talk about issues that were most pertinent to them.

Data Analysis

Data transcripts were analyzed following the analytical protocol for IPA methodology (Smith & Osborn, 2003). IPA is philosophically underpinned by phenomenology and

hermeneutics (Smith, Flowers & Larkin, 2009). Phenomenology is concerned with foregrounding human experience (Husserl, 1931); and by using a phenomenological approach, researchers are attempting to understand the world as participants perceive it, obtaining their idiosyncratic viewpoints (Smith et al., 2009). The double hermeneutic analytical approach in IPA means that during the research process the participant is trying to make sense of their own experiences and, in turn, the researcher aims to make interpretations of what has been represented during the interviews (Smith, 2015). This process can be criticized for being overly subjective, however IPA requires an interpretative process, and this level of subjectivity is not perceived as an epistemological limitation, but instead as an important part of the research process (Willig, 2013). In IPA, the researcher is central to the interpretative process and responsible for engaging with and interpreting the data. This means that the researchers' own life experiences, ideologies and knowledge can shape the findings as one must draw on their own existence for successful interpretation (Willig, 2013). However, throughout the research process, the authors made conscious attempts to maintain reflexivity, whilst acknowledging that individual bias may have influenced interpretations.

The analytical process consisted of several stages. Each transcript was read, then re-read to gain familiarity with the data, with preliminary notes and comments made through a free textual analysis (Smith, 2015). All eight transcripts were analyzed independently in this way, identifying emergent themes, before identifying commonalties and patterns across all cases. Salient themes were identified across all cases and clustered to create superordinate themes. In order to maintain credibility of analysis, all authors read the transcripts, and the second and third authors systematically audited the final list of super-ordinate and subordinate themes to ensure agreement of the hierarchical structure of themes and representation of data. Once authors had

agreed upon the hierarchical structure of themes, verbatim extracts were chosen to support these, in order to retain the voice of the participants. The superordinate themes presented in this article are reflective of all eight participants' experiences of GD.

Results

Thematic Structure of Adult Transgender Transitioning Experience

Three superordinate themes emerged from the experience of UK-based individuals with GD seeking healthcare treatment within the NHS. Superordinate themes included: "Accessing Healthcare Services," "Searching for Acceptance," and "Impact of Gender Dysphoria on Psychological Wellbeing." Each superordinate theme will be explained in detail and data examples are presented to illuminate the proposed thematic concepts.

Superordinate theme 1: Accessing healthcare services.

This theme encompasses participants' experiences of accessing treatment for GD, from their initial diagnostic visit with their physician to receiving treatment in a GIC. Participants described the initial feelings of having GD and the uncertainty associated with the experience. Some felt as though they "did not have the words for it" (Rebecca) and could not "put a label to it" (David). Others believed they were gay and used phrasing such as "alien and strange" (Candice) to describe their feelings pre-transition. However, participants gained an understanding that they had GD through obtaining information through documentaries, through talking to close friends (some of whom were gender non-conforming) and using forums on internet. When aiming to seek treatment for GD, participants felt as though there was a lack of support and information from their physician about the process of transitioning. Alice felt as though the referral process "was just box ticking" for doctors and reported that their physician

did not explain the gender reassignment procedures or the options of hormone therapy thoroughly.

When participants eventually sought a diagnosis of GD and were referred for treatment with the GIC, many were concerned about the length of time they would be waiting to begin treatment. Only two participants evaluated their GIC referral process favorably. One person explained that their NHS GP was very supportive and reassured her that they would "get this sorted" (Rebecca). The other participant, Bianca explained that her favorable experiences were as a result of accessing private healthcare. Bianca explained that '*by going private*' she had an appointment within a month of contacting the GIC.

In contrast, the remaining participants reported a sense of frustration and anxiety when waiting for initial appointments for the GIC and felt let down by the current NHS protocol for treating GD. For example, Elizabeth reported that she had been waiting over four years for her first appointment to the GIC and described how this situation emotionally impacted her:

> Extract 1 – I know people who have been through the clinic, and are on hormones now and I am still waiting for my first appointment. It's a bit of a punch in the gut […] I know a lot of trans people, and I try not to seem jealous, but it seems that every time I try and push to get it moving, there is an equal force pushing back. I can't move it. I just want to get to the point where I don't wake up in the morning and feel terrible. Where I don't walk past a mirror and it's hard to look into. It's got to the point now where we have talked about going private. (Elizabeth, 24)

Elizabeth highlights how the long waiting time to access treatment within the NHS has impacted her psychologically. As a result of struggling to live each day as someone incongruent to her self-perception, Elizabeth continues to feel uncomfortable with her appearance. She has contemplated

seeking private healthcare to access treatment quicker. This view was consistent with many participants in this study who realized that seeking private healthcare was the only way to bypass the long waiting times and receive gender confirmation surgery (or in particularly unsatisfactory cases for some clients, to even receive hormone therapy). However, for many, financial limitations acted as a barrier to accessing private healthcare.

Whilst waiting for their initial appointment with the GIC, participants explained that the lack of communication from the GIC lead to angst about their position on the waiting list. Participants felt they needed reassurance that they had not been forgotten about, reporting that whilst waiting, they "don't know what's happening" (Candice). Stephen describes the anxiety he felt whilst waiting for a date for his first appointment:

> Extract 2 - I had a letter to say they had received my referral and that's it. I have emailed them a couple of times to say my address has changed […] but apart from that when I've made first contact, I've heard nothing. Absolutely nothing. Which is kind of worrying since you are on the waiting list two years you would think you would get a letter every six months or something just to keep you updated. It makes you feel like you have been dropped off the system. […] It makes me worry that even though I am on the system, I have been forgotten about and like I was just another number on a spreadsheet as opposed to an actual person waiting for a service on the NHS. (Stephen, 22)

As a result of minimal contact Stephen felt let down by and lost within the healthcare system. Stephen expressed a concern over a perceived lack of continued acknowledgement by healthcare professionals at the GICs, feeling dehumanized as he believed he was only a "number on a spreadsheet". In general, participants in this study expressed dissatisfaction with the process of

accessing treatment within the NHS, and they proposed that continued support and acknowledgement is key to ensuring the process of transitioning is as easy as possible.

Superordinate theme 2: Searching for acceptance.

Participants found initial discussions about the prospect of transitioning particularly difficult with friends and family. Most participants in this study discussed the importance of familial acceptance during their transition but struggled with informing them. Participants were often apprehensive about informing their families, in fear of rejection. Many participants had delayed informing families vis-a-vis and had either sent a SMS text message or a letter instead of verbal communication.

Stephen explained that his mother was embarrassed at the prospect of him transitioning and seemed enraged when he posted on social media about it. As a result, Stephen was left feeling guilty that he has caused tension within the family. In similar way, Zoe-Ann explained that her parents would deliberately fail to use the correct pronoun in “a very aggressive manner”. Alice’s family were reported to be more concerned about upholding the family’s reputation than the well-being of their daughter. Alice’s family believed that “Everyone will think you are disgusting. Everyone is going to think we are disgusting, and we do not want the neighbors thinking that”. Participants perceived that the tension between family members led to a break down in family relationships; with some participants losing contact with their family altogether. Alice explained that since her gender confirmation surgery, she has managed to rebuild the bond with her sister. However, her parents remain unwilling to accept her new gender identity. In the following extract Alice reflects upon feeling unsupported by her parents:

> Extract 3 – [They say] we have lost a son. They are not understanding that they have destroyed a trans kid. […] They haven’t realized that they have gained a daughter. I

> suppose to them, they have lost a son, but they have a daughter which they could be supportive of instead, but they won't. […] My mum still asks my sister if she has heard from the old me. How can you ask you have heard from a person which no longer exists? Why can they not treat me like their daughter? (Alice, 30)

Alice felt a strong urge for acceptance from her parents and struggled to understand why her parents would not acknowledge that she was transgender. This feeling was echoed by many participants in this study, who recounted their desire and multiple attempts to interact with parents and to rebuild family bonds. Elizabeth reported that she strived for acceptance from her mother for multiple years and has "cried for hours because it is hard not having your family accept you". Evidently, acceptance from family plays an important role on ease of transition. In contrast, participants stated they had little challenges in social interactions with friends. Many of their friends had a pre-existing expectations of their intention to transition, and therefore showed a positive and supportive response. Participants considered the support from friends to have a positive effect during transitioning, with some intervening when they were met with social challenge in public areas.

With regard to challenges in the community, individual interaction varied, ranging from verbal abuse to a few experiencing immediate threats, such as threats of violence. The majority of participants discussed less immediate negative experiences occurring at home and in social situations. Experiences often focused on the repetition of targeted events when transphobic slurs were used, and these experienced resulted in fear and feelings of vulnerability. Two participants had suggested that the extent of the targeted transphobic attacks had made them fearful to leave the house, resulting in isolation through social withdrawal. Zoe-Ann described how the negative social encounters have changed her perceptions of herself when living as her true self:

> Extract 4 – For the first couple of months I was super giddy and happy that I was moving forwards. A sense of progress was amazing. Then that elation faded a bit. […] With the harassment building up more and more. One individual incident you can get through, however when it becomes daily, it reinforces it and becomes death by a thousand cuts. It really puts pressure on you and makes you feel like you shouldn't exist. The first couple of times were like […] I'm finally doing this, but then it gets harder with the abuse and bullying. […]. There's only so much you can bare before breaking down. (Zoe-Ann, 22)

For Zoe-Ann, living as a transgender woman resulted in continued and prolonged judgement and verbal aggression in her social sphere. The negative attitudes of others and lack of social acceptance had pushed her to the limits of society, resulting in a feeling of worthlessness. The impact of a lack of social acceptance has resulted in Zoe-Ann struggling to continue to accept her new gender identity. She changes from responding and viewing her transition as a positive period of change to one that is causing distress. The participants in this study display a search for acceptance and approval when transitioning, but negative social interaction, including repeated incidents of discrimination can present challenges to self-perceptions and mental wellbeing.

Superordinate theme 3: Impact of gender dysphoria on psychological wellbeing

The subject of mental health both pre- and post-transition was raised by participants in this study. Participants explained that there were barriers to accessing mental health support during transition, and they perceived there to be limited or no mental health support offered at GICs. Amongst transgender persons in this study, they reported feelings of depression, anxiety, and experiencing self-harm and suicidal thoughts.

During the pre-transition phase participants reported that they perceived that GD was one of the main drivers for suicidal attempts, explaining that suicidal thoughts were driven by learning of the long waiting times to receive support. This led to suicidal thoughts because "there was no way of getting through it quickly" (Candice). Mental health problems arose during transition, for example, living with feelings of low self-worth and being self-critical of their physical appearance. Clients expressed that they 'loathed' their body image, which was a key factor negatively affecting their mental health. One participant expressed that their body made them feel "not even human and a gross thing which shouldn't exist" (Zoe-Ann). Zoe-Ann feels a disassociation from her body, unable to reconcile her identity and her humanity. Her dissatisfaction is further exemplified when she distanced herself from her own body by referring to it as a "thing" before claiming that it "shouldn't exist." These similar feelings of dissatisfaction were mirrored by Rebecca who suggested that, pre-transition, strong feelings of body dissatisfaction, which led to depression and feelings of isolation and ultimately this resulted in suicidal ideation:

> Extract 5 – I was just happily awaiting at my local train station, when I was overcome with this urge to get up and jump as the train was approaching. I had been thinking about the problems I had been facing and what was going on. My body took over. […] I do not know what happened, I was in a flood of tears and horrified. What scares me most was that there was no decision, it was impulse and that was the most frightening thing of all. […] I phoned a taxi and headed home, I was in tears and shaking. Through that happening I knew that I had to do something, so I made the decision to ring and make an appointment to see a private doctor because when I looked online all the gender clinics

> seemed several years waiting time. I could not face that long a wait with how I was feeling. (Rebecca, 40)

However, positive psychological well-being was created through engaging with treatment in GICs. Participants explained that although the process of accessing treatments presented challenges, they explained that receiving gender confirmation surgery was a step in the right direction in changing their mental state. Rebecca explained:

> Extract 6 – People think it's the year after starting hormones… that's when things get better, but to be honest, it is more when you have the relief that you will be getting surgery that makes the most important step of change in the mental state. Trying to transition is very difficult […] so hell whilst waiting and going through all the hoops. But when you do, you prosper and it's such a life changing experience for someone with gender identity issues. (Rebecca, 40)

As Rebecca clarifies, there are barriers to accessing the medical intervention, and it is a long difficult process for the transgender community, but the long-term benefits of medical intervention outweigh the negatives. Additionally, the participants in the study explained that their goal was not just to transition but to "pass" as cisgender; that is a transgender person's ability to be perceived by others as their true gender identity. Elizabeth described her experience when she was correctly addressed as *Miss*, instead of being addressed as her assigned gender at a social event:

> Extract 7 – It's fantastic. We went to a gig recently and I was called Miss. […] I just couldn't stop smiling. You know I put the effort in, and it's paying off, felt great. (Elizabeth, 24)

These examples emphasize how the participants' decision to transition came at the expense of their mental health. However, seeking treatment from GICs are a step in the right direction to potentially alleviate some of the psychological distress associated with GD.

Discussion

Using an IPA approach, this study adds to the small body of existing literature in this field by offering a rich understanding of some of the challenges experienced by individuals with GD in the UK as they attempt to transition. Overall, it seems that the negative experiences of seeking treatment marred the positive effects that gender transition and gender confirmation surgery brought. The study revealed that accessing appropriate healthcare and treatment for GD was fundamental to alleviating distress, and this was reflective of existing literature (Hadj-Moussa, Ohl, & Kuzon, 2018). However, the process of attempting to access treatment often caused frustration and further anxiety, as the majority of participants in this study felt as though their physician provided little support and guidance in helping to understand the process of transitioning. It was evident from all interviews that the long waiting time for the first appointment at the GIC was a source of psychological distress. In particular, the lack of communication during this waiting time was especially disconcerting. Participants suggested that increased contact between clients and gender clinics during the waiting period, even via email, would help participants to feel valued and supported whilst under the care of NHS. These findings provide support for statistics provided by Bachmann and Gooch (2018), who reported that the transgender community are entirely dissatisfied by the support provided by both their physician and GIC. Given that long waiting times for accessing GICs can impact on the wellbeing of those with GD, there is evidence to suggest that capacity and availability of GICs in the UK needs to be substantially increased.

For this sample of transgender individuals, it is evident that social acceptance, particularly from their family was a critical element of psychological wellbeing. Initially, when informing their family of their intention to transition, many of these participants experienced rejection and unfavorable reactions including anger, embarrassment and lack of empathy. Furthermore, the tension and conflict caused family relationships to breakdown. These findings highlight the potential value of increased resources and support services for the families of individuals who are transitioning.

Social interactions in the public sphere presented challenges for participants with many experiencing transphobia and, in some instances, transphobic violence, leading to an intense feeling of vulnerability. This highlights how, in addition to providing support for families during transition, agencies involved should offer advice to transgender clients for dealing with transphobia. This may enable transgender people to not only feel safe in society, but also more confident in dealing with any transphobic instances that do arise.

Implications for Counseling Support

The proposal in the RCP (2013) guidelines for good practice emphasizes the importance of psychological counseling support in the early stages of treatment seeking, during treatment and post-treatment, have been strongly supported by the findings of the current study. This study has highlighted the impact of gender dysphoria on psychological wellbeing; clients were critical of their own body image, anxious and often had suicidal thoughts. Counseling could help to address these elements of psychological distress, enabling clients to feel supported during a time of uncertainty. It is evident by the waiting times between physician referral to a GIC and assessment and treatment is extensive in the UK if the client accesses healthcare via the NHS. For the majority of the participants in this study, although private healthcare is expedient, the

cost is prohibitive. Furthermore, the participants in the current study articulated a high level of distress because of the immense uncertainty experienced during the extended waiting time in the referral process.

Clearly, the NHS must reconsider the resources allocated to GIC treatment to meet current demand. However, in the interim referral period before treatment it is proposed that psychological counseling should be a standard component of healthcare for GD clients (of which the client may opt-out). This could take the form of individual or group counseling or psychotherapy sessions. Attending these sessions would allow clients to have a point of contact during the referral process and reduce them from feeling 'forgotten' in the system.

Although research into the outcomes of transgender-specific counseling or psychotherapy is limited, literature does highlight how group psychotherapy could have the potential to be a cost-effective form of mental health care. For example, Heck, Croot and Robohm (2013) conducted a psychotherapy group for transgender clients lasting for 12 weekly meetings. During these sessions, clients identified treatment goals, engaged in role play and discussed a range of lived experiences, including their experiences of coming out and transitioning. Although the authors do not formally evaluate the effectiveness of these sessions, they do report how participants made progress towards their goals whilst simultaneously expressing a desire to continue with the sessions (Heck et al., 2013). If future research rigorously evaluates the effectiveness of this counselling format and proves to have a positive impact on psychological wellbeing, it could form the basis of interventions to be used to lessen the distress experienced by those with GD whilst waiting to be referred.

The WPATH Standards of Care (2012) propose that psychotherapy should be offered to assist client exploration of gender identifying role, gender expression and the negative impact of

gender dysphoria. The experiences of the clients in the current study support this proposal; as they discussed in detail the harassment they experienced in society because of their gender transitioning. However, the interpersonal conflict experienced within the client's family appeared to be more distressing to the client than social discrimination in wider society. Therefore, it is tentatively proposed that psychological counseling regarding familial relationships and conflict as a result of the client's decision to transition from their assigned gender, is likely to prove beneficial to the client (where appropriate). Furthermore, if the familial relationships cannot be, or should not be, ameliorated then psychological counseling can support the client in accepting and coping with familial rejection, to minimize harm associated with the transitioning experience. Evidence clearly shows that positive treatment prognosis is associated with reduced psychological distress (RCP, 2013), therefore psychological counseling prior to treatment is likely to add to the prospect of a positive outcome for each client.

Limitations and Future Research

This study provided a valuable contribution to the qualitative literature that explores the lived experiences of adults with GD. However, as a methodology, IPA does have epistemological limitations. Not only does it rely on extensive disclosure from participants, it also depends on their ability to articulate their experiences in a clear and meaningful way (Willig, 2013). Additionally, the analytic process relies upon the interpretation of data by the researcher. However, to sustain both personal and epistemological reflexivity, researchers made conscious attempts to ensure any biases and preconceptions were limited and controlled throughout both the interview and data interpretation processes by continually returning to the data.

It must be acknowledged that the data is only representative of the views and experiences of the eight participants. This limits the generalizability of this study's findings as the

experiences of transgender people in this study might not be applicable to the whole transgender community in the UK. For example, the participants within the current study were relatively homogenous in terms of seeking treatment in the UK within the NHS healthcare system, having goals such as aiming to *'pass as cis-gendered'*, and having currently lived in their true gender for at least one year. The specific context and experience of the individual with GD, as they seek treatment and transition will likely vary substantially across cultures, healthcare systems and personal contexts. Therefore, it is important to be cautious in attempting to extrapolate the current findings and apply them to all individuals experiencing GD.

Despite these limitations, this study highlights how IPA has allowed for an in-depth exploration of participants' idiographic experiences. Given that in this study the parents' struggle to accept their child's intention to transition, causing distress and anxiety to the individual with GD, it is worthwhile to investigate the lived experience of individuals with family members who are transitioning with GD, to understand how best to support both parties. Furthermore, as participants experienced transphobic abuse and violence, future research could explore social acceptance and the perceived understandings of GD from members of society who do not have GD or who are ignorant of the experience of GD. This could be a step towards increasing awareness and reducing the social stigma surrounding GD.

Conclusion

This study builds upon a small body of qualitative literature that seeks to understand the lived experiences of people with GD in the UK. The experience of transitioning is clearly challenging for the individual, and often leads to adverse social experiences from family and wider society. It is common for individuals with GD aiming to transition to feel ignored by healthcare practitioners, leading to distress and uncertainty at a time where they already feel highly

vulnerable. In order to alleviate these feelings of uncertainty, the NHS needs to implement counseling support in the interim between referral to a GIC and the first appointment. Overall, this study shows how GICs, physicians and counselors need to work together to ensure that people with GD are supported throughout the process of their transition, so that no one feels excluded or forgotten about.

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Conflict of Interest: The authors declare that they have no conflict of interest.

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